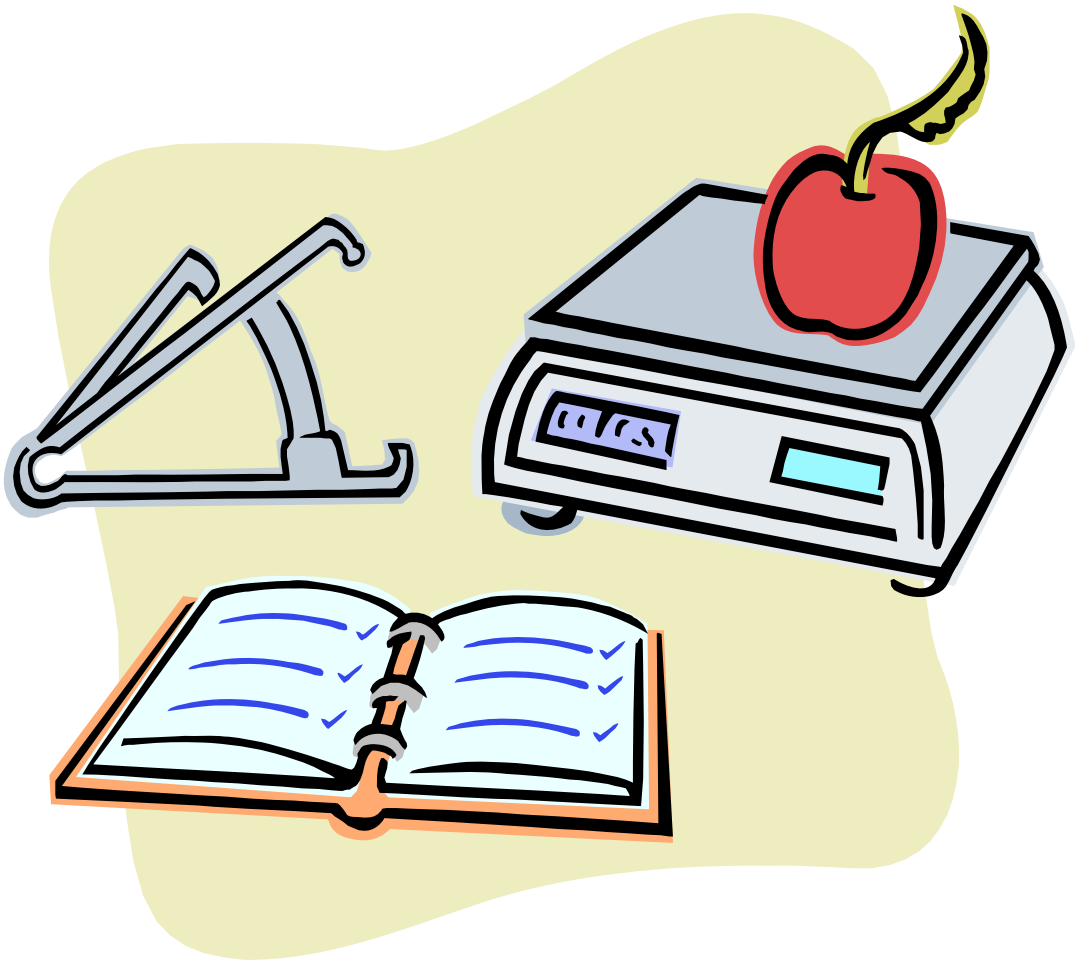
South Dakota Medical Assistance Program



Nutritional Therapy Manual

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INTRODUCTION

This manual is one of a series published for the use of medical services providers enrolled in the South Dakota Medical Assistance Program. It is designed to be readily updated by replacement or addition of individual pages as necessary. When such changes occur, **providers will be notified by Remittance Advice. It is important that the provider read the Remittance Advice messages each week for updates**. It is designed to be used as a guide in preparing claims, and is not intended to address all Medical Assistance Program rules and regulations.

Problems or questions regarding Medical Assistance Program rules and policies as well as claims, covered services, and eligibility verification should be directed to:

Department of Social Services
Office of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291
E-Mail: Medical@dss.state.sd.us
PHONE: (605) 773-3495

PROVIDER TOLL FREE NUMBER 1-800-452-7691
***Toll free telephone number is NOT to be given to recipients. This number is only to be used by the provider.**

The telephone service unit will not give out recipient ID numbers. The Medical Assistance Program emphasizes both the recipient's responsibility to present their ID card and the provider's responsibility to see the ID card each time a recipient obtains services (other than true emergency services.) It is to the provider's advantage to see the ID card to verify that the recipient is Medical Assistance Program eligible at the time of service, as well as to identify any other program limitations and the listing of the recipient name on the Medical Assistance Program file.

Problems or questions concerning **recipient eligibility requirements** can be addressed by the local field office of the Department of Social Services in your area or can be directed to:

Department of Social Services
Office of Economic Assistance
700 Governors Drive
Pierre, South Dakota 57501-2291
PHONE: (605) 773-4678

Medicare is a separately administered federal program and questions concerning Medicare cannot be answered by Medical Assistance Program personnel.

NOTE: If you are not currently submitting claims electronically and are interested in doing so, please contact our office for further information.

CHAPTER 1
GENERAL INFORMATION

The purpose of the Medical Assistance Program (Title XIX) is to assure the availability of quality medical care to low-income individuals and families through payments for a specified range of services. The Medical Assistance Program was implemented in South Dakota in 1967.

Federal and state governments under Title XIX of the Social Security Act share funding and control of the Medical Assistance Program. Regulations are written to comply with the actions of Congress and the State Legislature.

The following sections provide a description of general information about the program. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing the Medical Assistance Program in Article 67:16.

PROVIDER RESPONSIBILITY

ENROLLMENT AGREEMENT

A provider who renders a covered service to an eligible South Dakota Medical Assistance Program recipient, and wishes to participate in the Medical Assistance Program must apply to become an enrolled provider. The provider must sign a Provider Agreement with the Department of Social Services. Providers must comply with the terms of participation in the agreement and requirements stated in Administrated Rules of South Dakota (ASRD 67:16) which govern the Medical Assistance Program. Failure to comply with these requirements may result in monetary recovery, and/or civil or criminal action.

An agreement with a participating provider does not become effective until the department has approved and signed the agreement. A provider may not request reimbursement for covered services provided before the effective date, written on the provider agreement.

Participating providers agree to accept Medial Assistance Program reimbursement as payment in full for covered services. The provider must NOT bill any of the remaining balance to the recipient, their family, friends or political subdivisions.

An individual (i.e. employee, contractual employee, consultant etc.) who does not have a provider agreement, but who furnishes a covered service to a recipient under your provider agreement and receives payment or benefits indirectly from the Department of Social Services, is also subject to the rules, regulations and requirements of the Medical Assistance Program.

TERMINATION – AGREEMENT

When a provider agreement has been terminated the Department of Social Services will not pay for services provided after the termination date. A provider agreement may be terminated for any one of the following reasons:

1. The agreement expires;

2. The provider fails to comply with conditions of participation of the signed provider agreement;
3. The ownership, assets, or control of the provider's entity are sold or transferred;
4. Thirty days have elapsed since the department requested the provider to sign a new provider agreement;
5. The provider has requested termination of the agreement;
6. Thirty days elapse since the department provided written notice to the provider of its intent to terminate the agreement;
7. The provider has been convicted of a criminal offense that involves fraud in any state or federal medical assistance program;
8. The provider is suspended or terminated from participating in Medicare;
9. The provider's license or certification is suspended or revoked; or
10. Due to inactivity.

OWNERSHIP CHANGE

A participating provider who sells or transfers ownership or control of the entity must give the Department of Social Services written notice of the pending sale or transfer at least 30 days before the effective date. In a change of ownership, the seller is responsible for maintaining and ensuring access to records generated prior to the sale. This responsibility may be transferred to the buyer through a sales contract or written agreement. The Medical Assistance Program provider number is NOT transferable to the new owner. The new owner must apply and sign a new provider agreement and a new number must be issued before claims can be submitted.

RECORDS

Providers must keep legible medical and financial records that fully justify and disclose the medical necessity and extent of services provided and billed to the Medical Assistance Program. These records must be retained for at least six years after the last remittance date a claim was paid or denied. Records must not be destroyed when an audit or investigation is being conducted.

Agencies involved in the Medical Assistance Program review or investigation must be granted access to these records.

CLAIM SUBMISSION

The provider must submit the claim to a third-party liability source before submitting it to the Medical Assistance Program with the exception of for the following:

1. Prenatal care;
2. EPSDT screening services;
3. Prescription drug services;
4. Dental or orthodontic services;
5. Optical services;
6. Nursing home care; or
7. Annual Psych deductible is met.

The claim submitted to the Medical Assistance Program must have the notice of third-party payment or rejection attached to the claim. Failure to attach the notice to each claim will be cause for denial of the claim.

PAYMENTS

Once the provider has identified a third-party source, and, prior to requesting payment from the department, a completed claim for services must be submitted for payment to the third-party source. When the claim is subsequently submitted to the department for payment, evidence of third-party payment or rejection must accompany the claim. The provider is eligible to receive the amount allowed under the department's payment schedule less the third-party liability payment amount.

When the third-party payment equals or exceeds the amount allowed under Medical Assistance Program, the provider must not seek payment from the recipient, relative, or any legal representative.

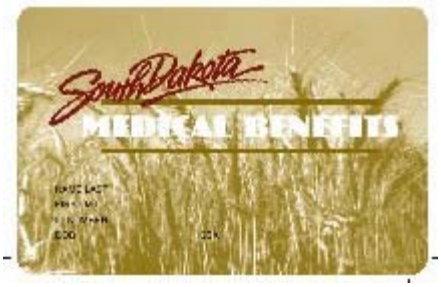
MEDICAL ASSISTANCE PROGRAM ID RECIPIENT ELIGIBILITY AND POLICIES

The South Dakota Medical Identification Card is issued by the Department of Social Services on behalf of eligible Medicaid recipients. The magnetic stripe card has the same background as the Food Stamp EBT card. The information on the face of the card includes the recipient's complete name (first, middle initial and last), the nine digit recipient ID (RID#) plus a three digit generation number, and the recipient's date of birth and sex.

NOTE: The three digit generation number is automatically added in the system to indicate the number of cards sent to an individual. This number is not part of the recipient's ID number and should not be entered on the claim.

Each card has only the name of an individual on it. There are no family cards.

Recipients must present their Medicaid identification card to a Medicaid provider each time, before obtaining a Medicaid covered service. Failure to present their Medicaid identification card is cause for payment denial. Payment for denied services becomes the responsibility of the recipient.



Medicaid eligibility verification system (MEVS) offers three ways for a provider to access the state's recipient eligibility file.

- *Point of Sale Device:* Through the magnetic strip, the provider can swipe the card and in about 10 seconds have an accurate return of eligibility information.
- *PC Software:* The provider can key enter the RID# into PC software and in about 10 seconds have an accurate return of eligibility information.
- *Automated Voice Response:* The provider who does not purchase equipment to access the plastic card will need to call the Office of

Medical Services' at, 1-800-452-7691 and receive eligibility information through the Automated Voice Response. This process takes approximately 1:15 minutes to complete a transaction and is only capable of reporting current (no previous) eligibility information.

Note: Please listen to the entire message when calling the Voice Response system.

MEVS ELIGIBILITY INFORMATION

Through the MEVS (card swipe or PC entry) the provider receives a paper or electronic receipt ticket, immediately upon eligibility verification (approximately 10 seconds). The following is an example of the "ticket' sent to the provider.

Please note that certain Medicaid recipients are restricted to specific limits on covered services. It is very important that you check for restrictions.

**********SD MEDICAID**********
Eligibility
10/19/2004 08:47:25

**********PAYER INFORMATION**********
Payer: SOUTH DAKOTA MEDICAL SERVICES
Payer ID: SD48MED

**********PROVIDER INFORMATION**********

Provider: MID-DAKOTA HOSP
Service Provider #: 9999999

**********SUBSCRIBER INFORMATION**********

Current Trace Number: 200406219999999
Assigning Entity: 9000000000
Insured or subscriber: Mertz, Ethel R.
Member ID: 999999999
Address: Pierre Living Center
2900 N HWY 290
PIERRE, SD 575011019
Date of Birth: 06/21/1908
Gender: Female

**********ELIGIBILITY AND BENEFIT INFORMATION**********

*****HEALTH BENEFIT PLAN COVERAGE*********
ACTIVE COVERAGE
Insurance Type: Medicaid
13
Eligibility Begin Date: 10/19/2004

ACTIVE COVERAGE
Insurance Type: Medicare Primary
13
Eligibility Date Range: 10/19/2004 –
10/19/2004

*****HEALTH BENEFIT PLAN COVERAGE********
*****OTHER OR ADDITIONAL PAYER**********
Insurance Type: Other
Benefit Coord. Date Range: 10/19/2004-
10/19/2004
Payer: BLUE CROSS/BLUE SHIELD
Address: 1601 MADISON
PO BOX 5023
SIOUX FALLS, SD 571115023
Information Contact:
Telephone: (800)774-1255

TRANS REF #: 999999999

Over 150 payers now support eligibility requests. For a full list, contact fax-on-demand at 800-760-2804, #536. To add new payers, call 800-215-4730.

CLAIM STIPULATIONS

FORMS:

Providers are required to use the National Standard Form (HCFA 1500) to submit claims to the South Dakota Medical Assistance Program.

SUBMISSION

The provider must verify an individual's eligibility before submitting a claim, either through the ID card or in the case of long-term care, a letter from the caseworker. The provider must record the recipient identification information as required for the claim.

A provider may only submit claims for those items and services that the provider knows or should have known, are covered under the South Dakota Medical Assistance Program. A provider must not submit a claim for items or services that have not been completed or have not actually been provided. A provider can be reimbursed only for **medically necessary covered services actually provided** to Medical Assistance Program recipients eligible on the date the service is provided.

TIME LIMITS

The Office of Medical Services must receive a completed claim form within 12 months following the month the service was provided. This time limit may be waived or extended only if one or more of the following situations exist:

1. The claim is a replacement or void of a previously paid claim, and is received within six months after the previously paid claim;
2. The claim is received within six months after a retroactive initial eligibility determination was made as a result of an appeal;
3. The claim is received within six months after a previously denied claim;
4. The claim is received within six months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or
5. To correct an error made by the department.

PROCESSING

The office of Medical Services processes ***paper*** claims submitted by providers in the following manner:

1. Claims and attachments are received by the office of Medical Services and sorted by claim type and microfilmed;
2. Each claim is given a unique 14-digit **Reference Number.** This number is used to enter, control, and process the claim. An example of a reference number is 2004005-0011480. The first four digits represent the year. The next 3-digits represent the day of the year the claim was received. The next 7-digits are the sequential number order of the claims received on that day. Each line is separately adjudicated, reviewed and processed using the 14-digit reference number. However, claims with multiple lines will be assigned a single claim reference number.
3. All claims are separately entered into the computer system and will be completely detailed on the remittance advice.

To determine the status of a claim, you must reconcile your files with the information on the Remittance Advice.

UTILIZATION REVIEW

The Federal Government requires states to verify receipt of services. Each month a sample of Medical Assistance Program recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in non-technical terms, and confidential services are omitted. Although the directions are as clear as possible, providers should be prepared to assure any inquiring recipients that this letter is not a bill.

Under Federal rule 456.3, the Medical Assistance Program is mandated to establish and maintain a surveillance and utilization review system (SURS). The SURS unit safeguards against unnecessary or inappropriate use of Medical Assistance Program services or excess payments, and assesses the quality of those services. Federal rule 456.23 authorizes a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers.

Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by the Medical Assistance Program.

FRAUD AND ABUSE

The SURS unit is responsible for the identification of possible fraud and/or abuse. The South Dakota Medical Assistance Program Fraud Control Unit (MFCU) under the Office of the Attorney General, is certified by the Federal Government to detect, investigate, and prosecute any fraudulent practices or abuse against the Medical Assistance Program. Civil or criminal action or suspension from participation in the Medical Assistance Program is authorized under South Dakota Codified Law (SDCL) 22-45 entitled, Unlawfully Obtaining Benefits of Payments from Medical Assistance Program. It is the provider's responsibility to become familiar with all sections of SDCL 22-45 and ARSD Article 67:16.

DISCRIMINATION PROHIBITED

South Dakota Medical Assistance Program, participating medical providers, and contractors may not discriminate against Medical Assistance Program recipients on the basis of race, color, national origin, age, sex or disability. All enrolled Medical Assistance Program providers must comply with this non-discrimination policy.

MEDICALLY NECESSARY

Medical Assistance Program covered services are to be payable under Medical Assistance Program when the service is determined medically necessary by the provider. To be medically necessary, the covered service must meet all of the following conditions:

1. It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
2. It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
3. It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
4. It is not furnished primarily for the convenience of the recipient or the provider; and
5. There is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

CHAPTER II
NUTRITIONAL THERAPY

INTRODUCTION

Nutritional therapy is covered under the South Dakota Medical Assistance Program for individuals when ordered by the physician as part of the care and treatment of a medical condition or a malfunction in the gastrointestinal tract. Nutritional therapy must be the sole source of nutrition for individuals over the age of 21 years. Nutritional supplementation is covered for individuals under the age of 21 years.

DEFININTIONS

(1) "Enteral nutritional therapy," nutritional therapy by way of the small intestine through nasogastric, jejunostomy, or gastrostomy tubes;
(2) "Nutritional supplement," specialized formulas required to increase a child's daily protein and caloric intake;
(3) "Nutritional therapy," specialized formulas or hyperalimentation which serves as the sole means of nutrition and is required when nutrition cannot be sustained through oral feedings due to a chronic illness or trauma; and
(4) "Parenteral nutritional therapy," nutritional therapy by intravenous injection or also referred to as total parenteral nutrition (TPN).

PROVIDERS

Nutritional therapy may be billed to the South Dakota Medical Assistance Program by an enrolled durable medical equipment (DME) or pharmacy provider. These claims must be submitted on a HCFA 1500 claim form.

NUTRITIONAL THERAPY

Nutritional Therapy for individuals under the age of 21 years

Enteral nutritional therapy, oral nutritional supplements, and electrolyte replacement for individuals under 21 years of age are covered when the following conditions are met:

- The individual is not institutionalized and services are delivered in the individual's residence. An individual's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for individuals with a mental disease;
- The items are ordered by a physician as part of the care and treatment of a medical condition or a malfunction in the gastrointestinal tract.
- Oral nutritional supplements are covered for a child with a medical condition that cannot maintain normal protein or caloric intake.

No prior authorization is required. However, the provider must keep a current Nutritional Certificate of Medical Necessity (Appendix A), and physicians prescription on file.

Nutritional therapy for individuals over the age of 21 years
Enteral nutritional therapy for an individual who is 21 years of age or older is covered if all of the following conditions are met:

- The individual is not institutionalized and services are delivered in the individual's residence. An individual's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for individuals with a mental disease;
- The nutritional therapy is ordered by a physician as part of the care and treatment of a medical condition or a malfunction in the gastrointestinal tract.
- The provider has received prior approval from the department; and
- Enteral nutritional therapy is the sole source of nutrition and the only means the individual has to receive nutrition.

Prior authorization required -- nutritional therapy over age of 21 years. The department must authorize the use of enteral nutritional therapy for an individual 21 years of age or older before the service is payable. Before authorization is given, the physician/provider must submit the following to the department:

- A copy of the prescription for the needed therapy;
- A copy of the nutritional certificate of medical necessity signed by the physician giving the reasons the person is unable to receive adequate nutrition by normal means;
- The applicable procedure codes for the nutritional formula;
- The provider's usual and customary charge for the items or services, including formula, durable medical equipment, and supplies; and
- Documentation regarding other requested routine medical services, such as home health services.

If there is no change in the physician's orders and the need for the nutritional therapy is identified as permanent by the physician, the authorization will be renewed on an annual basis.

If the therapy changes a new authorization must be obtained or if the condition is not permanent the authorization may not exceed six months.

The provider is responsible for submitting the documentation for a new authorization. Authorizations will be given from the date of contact.

Nutritional therapy and nutritional supplements -- Limits.

- Nutritional therapy, nutritional supplements, and electrolyte replacement are limited to those services listed in the Enteral Nutrition Product Classification List.
  Appendix A - List of Procedure Codes and Prices for Enteral Therapy, Oral Nutrition, and Electrolyte Replacement for Individuals Under 21 Yeas of Age.
  Appendix B - List of Procedure Codes and Prices for Enteral Therapy for Individuals Age 21 and Older.
  Appendix C - List of Procedure Codes and Prices for Parenteral Therapy.
- Nutritional supplementation for individuals 21 years of age or older is not covered.
- Enteral nutritional therapy for an individual that resides in an institutional setting is not covered.

TOTAL PARENTERAL NUTRITION

Parenteral nutritional therapy is covered if all of the following conditions are met:

- The individual is not institutionalized and services are delivered in the individual's residence. An individual's residence does not include an acute care hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for individuals with a mental disease;
- The individual has a medical condition such as severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the individual's general condition;
- Parenteral nutritional therapy is the only means the individual has to receive nutrition; and
- The provider has received prior approval from the department.

Total Parenteral Nutrition -- Prior authorization required. The department must authorize the use of parenteral nutritional therapy services before they are payable. Before authorization is given, the physician/provider must submit the following:

- A copy of the prescription for the needed therapy;
- A copy of the nutritional certificate of medical necessity signed by the physician and giving the reasons the person is unable to receive adequate nutrition by normal means;
- The applicable procedure codes for parenteral nutrition: see Appendix B
- The provider's usual and customary charge for the items or services, including formula, durable medical equipment, and supplies; and
- Documentation regarding other required routine medical services, such as home health.

If there is no change in the physician's orders and the individual has a permanent condition the authorization must be renewed annually.

For conditions that are not permanent, an authorization may not exceed six-months.

Authorizations are given from the date of contact.

Rate of payment. Payment for nutritional therapy, nutritional supplements, and electrolyte replacements is the lesser of the provider's usual and customary charge or the applicable fee established by the Medical Assistance Program.

When no fee is specified for nutritional formulas, payment is limited to 60 percent of the provider's usual and customary charge.

Equipment, supplies, and administration kits necessary to administer the parenteral or enteral nutritional therapy are covered under the provisions of chapter 67:16:29.

BILLING REQUIREMENTS

A provider submitting a claim for reimbursement under this chapter must submit the claim at the provider's usual and customary charge.

Costs of professional intervention services, such as nursing and dietary, which are pertinent to the parenteral therapy are included in the cost of the parenteral therapy.

The claim must contain the applicable procedure codes.

Enteral nutrition is billed at 100 calories = 1 unit

Claims for services may not be submitted unless the provider obtained approval from the department before the services were provided.

A claim for intermittent home health skilled nursing visits must meet the requirements of chapter 67:16:05.

UTILIZATION REVIEW

The department may conduct utilization reviews of nutritional therapy and nutritional supplements during computerized claims processing and post-payment review.

CHAPTER III

BILLING INSTRUCTIONS

The following instructions apply to paper claims only.

HCFA 1500 CLAIM FORM

The HCFA 1500 form substantially meets the requirements for filing covered services for physician services. It has been designed to permit billing for up to six services for one recipient.

The South Dakota Medical Assistance Program does not provide this form. These forms are available for direct purchases through either of the following agencies.

Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402
(202) 512-1800 (pricing desk)

OR

American Medical Association
P O Box 10946
Chicago, IL 60610
ATTN: Order Department

If you prefer to have your own forms printed, negatives and reproducibles are available from:

Government Printing Office
Room C836, Building 3
Washington, DC 20401

CODES

The procedure codes allowed for filing covered practitioner services are found in the most current CPT and HCPC manuals.

SUBMISSION

The original filing of claims must be within 12 months of the date of service, unless third party liability insurance is involved or initial retroactive eligibility is determined as listed in Administrative Rule 67:16:35:04.

A provider may only submit a claim for services the provider knows or should have known are covered by the South Dakota Medical Assistance Program.

A claim must be submitted at the provider's usual and customary charge for the service, on the date the service was provided.

The name that appears on the remittance advice indicates the provider name that the South Dakota Medical Assistance Program associates with the assigned provider number. This name must correspond with the name submitted on claims.

Failure to properly complete provider name and address as enrolled with the South Dakota Medical Assistance Program could be cause for non-processing or denial of the claim by Medical Assistance Program.

The original HCFA 1500 claim form is to be submitted to the address listed below. The copy should be retained for your records.

Department of Social Services
Office of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

The provider is responsible for the proper postage

HOW TO COMPLETE THE HCFA 1500 CLAIM FORM

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by Medical Assistance Program.

THE FOLLOWING IS A BLOCK BY BLOCK EXPLANATION OF HOW TO PREPARE THE HEALTH INSURANCE CLAIM FORM HCFA 1500.

Please do not write or type above block 1 of the claim form. It is used by South Dakota Medical Assistance Program for control numbering.

BLOCK 1 HEADINGS
Place an "X" or check mark in the South Dakota Medical Assistance Program block. If left blank, South Dakota Medical Assistance Program (Medical Assistance Program) will be considered the applicable program.

BLOCK 1a INSURED'S ID NO. (*MANDATORY*)
The recipient identification number is the nine-digit number found on the South Dakota Medical Assistance Program Identification Card. **The three-digit generation number that follows the nine-digit recipient number is not part of the recipient's ID number and should not be entered on the claim.**

BLOCK 2 PATIENT'S NAME (*MANDATORY*)
Enter the recipient's last name, first name, and middle initial.

BLOCK 3 PATIENT'S DATE OF BIRTH/SEX
If available, please enter in this format. MM-DD-YY.

PATIENT'S SEX
Optional

BLOCK 4 INSURED'S NAME
Optional

BLOCK 5 PATIENT'S ADDRESS
Optional

BLOCK 6 PATIENT'S RELATIONSHIP TO INSURED
Optional

BLOCK 7 INSURED'S ADDRESS
Optional

BLOCK 8 PATIENT STATUS
Optional

BLOCK 9 OTHER INSURED'S NAME (*MANDATORY*)
If the recipient has more than one other insurance coverage, provide the requested information in blocks 9, 9a, 9b, 9c, 9d, if known.

BLOCK 10 WAS CONDITION RELATED TO

A Patient's Employment-If the patient was treated due to employment-related accident, place an "X" in the YES block, if not, place an "X" in the NO block or leave blank.

B/C Accident-If the patient was treated due to an auto accident, place an "X" in the appropriate block. If other type of accident, place an "X" in the OTHER block and explain. If not an accident, leave blank.

D Reserved For Local Use-Enter one of the following, if applicable: "U" for Urgent Care; "I" for Contract Providers; "D" for Dental Services; or "E" for Managed Care Exemption Code.

BLOCK 11 INSURED'S POLICY GROUP OR FECA NUMBER(*MANDATORY)*
If the recipient has other health insurance coverage (Aetna, Blue Cross, Tri-Care, School Insurance, etc.) provide the requested information in blocks 11, 11a, 11b, 11c, if known. If the recipient has more than one other insurance coverage check "YES" block 11d. If "YES" is checked in block 11d, provide the requested information in blocks 9, 9a, 9b, 9c, 9d, if known.

BLOCK 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 14 DATE OF CURRENT ILLNESS
Optional

BLOCK 15 IF PATIENT HAS HAD SAME ILLNESS OR SIMILAR ILLNESS
Optional

BLOCK 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
Optional

BLOCK 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
If the recipient was a referral, enter the referring physician's or (other sources) name. Optional, but very helpful.

BLOCK 17a ID NUMBER OF REFERRING PHYSICIAN
If recipient was a referral, enter the referring physician's or (other sources) provider number. This is ***mandatory*** for Managed Care recipients not treated by their PCP.

BLOCK 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Optional

BLOCK 19 RESERVED FOR LOCAL USE
Not applicable, leave blank.

BLOCK 20 OUTSIDE LAB
Place an "X" in the "YES" or "NO" block. Leave the space following "Charges" blank. If not applicable, leave blank.

BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (MANDATORY)
Diagnosis codes and descriptions 1, 2, 3, and 4 – Enter the appropriate five digit diagnosis code(s) which best describe the reason(s) for treatment or service, listing the primary in position "1", secondary in position "2", etc.
These codes must be ICD-9 codes. "E" codes are not used by the South Dakota Medical Assistance Program. "V" codes are acceptable.

The following claims are exempt from diagnosis code requirements:

1. Anesthesia;
2. Ambulatory Surgical Center;
3. Audiology;
4. Laboratory or pathology;
5. Physical Therapy;
6. Radiology; and
7. Transportation

BLOCK 22 SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM RESUBMISSION NUMBER
Required for replacements and voids only.

BLOCK 23 PRIOR AUTHORIZATION NUMBER
Enter the prior authorization number provided by the department, if applicable.

BLOCK 24 Use a separate line for each service provided. If more than six services were provided for a recipient, a separate claim form for the seventh and following services must be completed.

A **DATE OF SERVICE FROM – TO (*MANDATORY)***
Enter the appropriate date of service in month, day, and year sequence, using eight digits.

	FROM	TO
Example:	01/24/2004	01/24/2004

B **PLACE OF SERVICE (*MANDATORY)***
Enter the appropriate place of service code.
Code values:

11	Office
12	Home
21	Inpatient hospital
22	Outpatient hospital
23	Emergency Room-Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance-Land
42	Ambulance-Air or Water
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Unlisted Facility

C TOS (TYPE OF SERVICE
Optional – you may enter the appropriate type of service.

D **PROCEDURE CODE (*MANDATORY)***
Enter the appropriate five character HCFA Common Procedure Coding System (HCPC) procedure code for the service provided. Enter the appropriate procedure modifier, if applicable. See Appendix A, B, or C of Administrative Rule Chapter 67:16:02 for a listing of procedure codes.

NOTE: Use the same procedure code only once per date of service.

E DIAGNOSIS CODE (*MANDATORY)*
Optional – you may enter codes as entered in Block 21.

F **CHARGES *(MANDATORY)***
Enter the provider's usual and customary charge for this service or procedure.

G **DAYS OR UNITS *(MANDATORY) (if more than one)***
Enter the number of units or times that the procedure or service was provided for this recipient during the period covered by the dates in block 24a. If this is left blank, reimbursement will be for one unit/time (15 minutes).

H EPSDT – FAMILY PLANNING
Early and Periodic Screening, Diagnosis and Treatment. If services were provided because of an EPSDT referral, enter an "E", if not, leave blank.

FAMILY PLANNING
Not applicable, leave blank.

I EMG
Not applicable, leave blank.

J COB
Not applicable, leave blank.

K LEAVE BLANK – EXCEPT FOR GROUP PROVIDERS
Group providers approved by the South Dakota Medical Assistance Program, enter the seven digit Medical Assistance Program provider number of the physician providing the care or service. All other providers leave blank.

BLOCK 25 FEDERAL TAX ID NUMBER
Optional

BLOCK 26 YOUR PATIENT'S ACCOUNT NO.
Enter your office's patient account number, up to ten numbers, letters, or a combination thereof is allowable.

Examples: AMX2345765, 9873546210 and YNXDABNMLK
NOTE: Block 26 optional, included for your convenience only. Information entered here will appear on your remittance advice when payment is made. If you do not wish to use this block, leave it blank.

BLOCK 27 ACCEPT ASSIGNMENT
Not applicable, leave blank.

NOTE: The South Dakota Medical Assistance Program can only pay the provider, not the recipient of medical care.

BLOCK 28 TOTAL CHARGES
Optional

BLOCK 29 AMOUNT PAID *(MANDATORY)*
If payment was received from private health insurance, enter the amount received here. (Attach a copy of the Insurance Company's remittance advice or explanation of benefits behind each claim form.) The Office of Medical Services will allocate that payment to each individual line of service as necessary. If payment was denied, enter 0.00 here (attach a copy of insurance company's denial).

NOTE 1: Do not subtract the other insurance from your charge.

NOTE 2: South Dakota Medical Assistance Program's Cost Sharing (recipient's payment), if applicable is not considered a payment from other source – do not enter on claim.

BLOCK 30 BALANCE DUE
Optional

BLOCK 31 SIGNATURE OF PHYSICIAN OR SUPPLIER *(MANDATORY)*
The invoice must be signed by the provider or provider's authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed. **Claims will not be paid without signature and date completed.**

BLOCK 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
Optional

BLOCK 33 **PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE, AND TELEPHONE NO.** ***(MANDATORY)***

Enter the billing provider's name as listed on the South Dakota Medical Assistance Program Provider file and complete address. The telephone number is optional, but is helpful if a problem occurs during processing of the claim.

ID NO. ***(MANDATORY)***

Enter your seven-digit Provider Identification Number, which was assigned by the South Dakota Medical Assistance Program.

SUBMITTING VOID AND REPLACEMENT REQUESTS

Claim level processing links all lines of a claim for purposes of posting and reporting. Each line is evaluated separately for payment, but the lines are all reported under a single claim reference number. In other words, all lines submitted on a single claim form will have a single claim reference number assigned to them.

The necessary processing is described in detail below. We believe that these procedures will result in less work for your staff and quicker processing thought the Medical Assistance Program claims payment system.

VOID REQUEST

A void request asks the Medical Assistance Program to take back all the money paid for a claim. Every line is reversed. A paid line has the payment taken back from it. A denied line remains denied. A pending line is denied. The transaction is shown on your remittance advice and the money taken back is deducted from any payment that may be due to you.

To submit a void request, follow the steps below:

- Make a copy of your paid claim;
- In field 22, enter the word "VOID" at the left;
- In the same field, enter the claim reference number that Medical Assistance Program assigned to the original claim, at the right;
- Highlight field 22;
- Send the void request to the same address you have always used; and
- Keep a copy of your request for your files.

If the original claim reference number is not shown in the void request, it will not be processed, and will appear on your remittance advice as an error.

Once a claim has been voided, it cannot be reversed and repaid. You must submit a new claim.

REPLACEMENT REQUEST

A replacement request consists of two steps. First, a credit adjustment, or void is generated by the claims payment system, for each line on the original claim and processed. This part of the transaction works as described in void processing, above. The corrections you supply are entered and the entire claim is reprocessed. A paid line can be increased or decreased. A

denied line remains denied, and a pended line is also denied. The replacement claim may include more or fewer lines than the original. The transaction is shown on your remittance advice and changes in payment are added to or deducted from any payment that may be due to you.

To submit a placement request, follow the steps below:

- Make a copy of your paid claim;
- In field 22, enter the word **REPLACEMENT** at the left;
- In the same field, enter the claim reference number that Medical Assistance Program assigned to the original claim, at the right;
- Highlight field 22;
- Indicate corrections to the claim by striking through incorrect information and entering corrections. You may use correction fluid or tape to remove incorrect information and replace with correct information;
- Highlight all the corrections you have entered;
- **Do not** attach additional separate pages or use post-it notes. These may become separated from your request and delay processing;
- Send your replacement request to the same address you have always used; and
- Keep a copy of your request for your files.

An original claim can be replaced only once. You may, however, submit a void or replacement request for a previously completed replacement. In this case, enter VOID or REPLACEMENT (as appropriate) in field 22 at the right and indicate the claim reference number of the replacement claim at the left. Highlight field 22, enter and highlight any corrections, as described above, and submit your request.

The Medical Assistance Program claims payment system links the original claim with subsequent replacement and/or void requests, to ensure that any transaction is only replaced or voided once.

CROSSOVER CLAIM SUBMISSION

The crossover claim form substantially meets the requirements for filing claims for services for recipients who are dually eligible for both Medical Assistance Program and Medicare after Medicare has determined a deductible or co-insurance amount is due.

Crossover claims are to be submitted on the appropriate National Claim Form, either a HCFA 1450 or HCFA 1500 form.

SUBMISSION

The original filing of services must be within 12 months of the date of service, unless third party liability insurance is involved or initial retroactive eligibility is determined.
The name that appears on the remittance advice indicates the provider name that the Medical Assistance Program associates with the assigned provider number. This name must correspond with the name submitted on claim forms.

Failure to properly complete provider name and address as registered with the South Dakota Medical Assistance Program could be cause for non-processing or denial of the claim by the Medical Assistance Program.

Because the Medical Assistance Program is the payer of last resort you must submit your claim to Medicare first. You must submit a crossover claim to the Medical Assistance Program when billing for the Medicare co-insurance and/or deductible. Proof of payment from Medicare (EOMB, voucher, etc.) must be attached to the crossover claim form.

DO NOT submit a crossover claim form if Medicare has denied payment.
Medical Assistance will not pay for any service that has been denied by Medicare as not medically necessary or reasonable. If Medicare's denial was for another reason, you may submit a HCFA claim form along with a copy of the Medicare denial for consideration of payment.

The Crossover claim is to be submitted to the address below. A copy is to be retained for your records

Department of Social Services
Office of Medical Services
700 Governors Drive
Pierre, South Dakota 57501-2291

The provider is responsible for the proper postage.

HOW TO COMPLETE THE MEDICARE CROSSOVER CLAIM ON THE HCFA 1500 CLAIM FORM

MANDATORY:
The provider **MUST** attach the Medicare Explanation of Benefits and any applicable third party explanation of benefits (EOB) to **EACH** crossover claim form. Crossover claims **cannot** be processed without the EOB.

Failure to properly complete **MANDATORY** requirements will be cause for non-processing or denial of the claim by the Medical Assistance Program.

THE FOLLOWING IS A BLOCK BY BLOCK EXPLANATION OF HOW TO PREPARE THE MEDICARE CROSSOVER CLAIM ON THE HEALTH INSURANCE CLAIM FORM HCFA 1500.

Please do not write or type above block 1 of the claim form. It is used by South Dakota Medical Assistance Program for control numbering.

BLOCK 1 HEADINGS
Place an "X" or check mark in the South Dakota Medical Assistance Program block. If left blank, South Dakota Medical Assistance Program (Medical Assistance Program) will be considered the applicable program.

BLOCK 1a INSURED'S ID NO. (*MANDATORY*)
The recipient identification number is the nine-digit number found on the South Dakota Medical Assistance Program Identification Card. **The three-digit generation number, that follows the nine-digit recipient number, is not part of the recipient's ID number and should not be entered on the claim.**

BLOCK 2 **PATIENT'S NAME (*MANDATORY*)**
Enter the recipient's last name, first name, and middle initial.

BLOCK 3 PATIENT'S DATE OF BIRTH
If available, please enter in this format. MM-DD-YY.

PATIENT'S SEX
Optional

BLOCK 4 INSURED'S NAME
Optional

BLOCK 5 PATIENT'S ADDRESS
Optional

BLOCK 6 PATIENT'S RELATIONSHIP TO INSURED
Optional

BLOCK 7 INSURED'S ADDRESS
Optional

BLOCK 8 PATIENT STATUS
Optional

BLOCK 9 **OTHER INSURED'S NAME (*MANDATORY*)**
If the recipient has more than one other insurance coverage, provide the requested information in blocks 9, 9a, 9b, 9c, 9d, if known.

BLOCK 10 WAS CONDITION RELATED TO
Not used for Medicare Crossover Claims

BLOCK 11 **INSURED'S POLICY GROUP OR FECA NUMBER(*MANDATORY)***
If the recipient has other health insurance coverage (Aetna, Blue Cross, Tri-Care, School Insurance, etc.) provide the requested information in blocks 11, 11a, 11b, 11c, if known. If the recipient has more than one other insurance coverage check "YES" Block 11d. If "YES" is checked in Block 11d, provide the requested information in Blocks 9, 9a, 9b, 9c, 9d, if known.

BLOCK 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 14 DATE OF CURRENT ILLNESS
Optional

BLOCK 15 IF PATIENT HAS HAD SAME ILLNESS OR SIMILAR ILLNESS
Optional

BLOCK 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
Optional

BLOCK 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
Optional for Medicare crossover claims

BLOCK 17a ID NUMBER OF REFERRING PHYSICIAN
Optional for Medicare crossover claims

BLOCK 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Optional

BLOCK 19 RESERVED FOR LOCAL USE
Not applicable, leave blank.

BLOCK 20 OUTSIDE LAB
Optional for Medicare crossover claims

BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
Not required for Medicare crossover claims:

BLOCK 22 SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM RESUBMISSION NUMBER
Not applicable leave blank

BLOCK 23 PRIOR AUTHORIZATION NUMBER
Optional for Medicare crossover claims

BLOCK 24 Use a separate line for each service provided. If more than six services were provided for a recipient, a separate claim form must be completed for the seventh and following services.

A **DATE OF SERVICE FROM – TO (*MANDATORY)***
Enter the appropriate date of service in month, day, and year sequence, using eight digits.

B **PLACE OF SERVICE (*MANDATORY)***
Enter the appropriate place of service code.

C TOS (TYPE OF SERVICE)
Optional – you may enter the appropriate type of service.

D **PROCEDURE CODE (*MANDATORY)***
Enter the appropriate five character HCFA Common Procedure Coding System (HCPC) procedure code for the service provided. Enter the appropriate procedure modifier, if applicable. See Appendix A, B, or C of Administrative Rule Chapter 67:16:02 for a listing of procedure codes.

NOTE: Use the same procedure code only once per date of service.

E DIAGNOSIS CODE
Not required for Medicare crossover claims

F **CHARGES *(MANDATORY)***
Enter your usual and customary charges billed to Medicare

G **DAYS OR UNITS *(MANDATORY) (if more than one)***
Not used for Medicare crossover claims

H EPSDT – FAMILY PLANNING
Not used for Medicare crossover claims

FAMILY PLANNING
Not used for Medicare crossover claims

I EMG
Not applicable, leave blank.

J COB
Not applicable, leave blank.

K MEDICARE CROSSOVER CLAIMS *(MANDATORY)*
Enter the provider paid amount plus any contractual adjustment and any other third party payment for each line of service on the HCFA 1500 claim form.

BLOCK 25 FEDERAL TAX ID NUMBER
Optional

BLOCK 26 YOUR PATIENT'S ACCOUNT NO.
Enter your office's patient account number, up to ten numbers, letters, or a combination thereof is allowable.

Examples: AMX2345765, 9873546210 and YNXDABNMLK

NOTE: Block 26 optional, included for your convenience only. Information entered here will appear on your remittance advice when payment is made. If you do not wish to use this block, leave it blank.

BLOCK 27 ACCEPT ASSIGNMENT
Not applicable, leave blank.

> **NOTE:** The South Dakota Medical Assistance Program can only pay the provider, not the recipient of medical care.

BLOCK 28 TOTAL CHARGES
Optional

BLOCK 29 AMOUNT PAID *(MANDATORY)*
Enter **TOTAL** amount paid by other payer not including Medicare

BLOCK 30 BALANCE DUE
Enter Medicare coinsurance and/or deductible due

BLOCK 31 SIGNATURE OF PHYSICIAN OR SUPPLIER *(MANDATORY)*
The invoice must be signed by the provider or provider's authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed. **Claims will not be paid without signature and date completed.**

BLOCK 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
Optional

BLOCK 33 PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE, AND TELEPHONE NO. *(MANDATORY)*
Enter the billing provider's name as listed on the South Dakota Medical Assistance Program Provider file and complete address.
The telephone number is optional, but is helpful if a problem occurs during processing of the claim.

ID NO. *(MANDATORY)*
Enter your seven-digit Provider Identification Number, which was assigned by the South Dakota Medical Assistance Program.

IMPORTANT NOTE FOR GROUP PROVIDERS:
You must enter the seven digit South Dakota Medical Assistance provider identification number of the servicing provider at PIN # location.
Also enter GRP # as indicated

A separate claim form must be used for each recipient.

CHAPTER IV

REMITTANCE ADVICE

The Remittance Advice serves as the Explanation of Benefits (EOB) from the Medical Assistance Program. The purpose of this chapter is to familiarize the provider with the design and content of the Remittance Advice. The importance of understanding and using this document cannot be stressed enough. The current statuses of all claims, (including Replacements and voids) that have been processed during the past week are shown on the Remittance Advice. **It is the provider's responsibility to reconcile this document with patient records.** The Remittance Advice documents all payments and denials of claims and should be maintained for six years, pursuant to SDCL 22-45-6.

EACH CLAIM LINE IS PROCESSED SEPARATELY
Use the correct reference number (see chapter 1) to ensure that you correctly follow each line of a claim. The following information explains the Remittance Advice format:

HEADER INFORMATION

- South Dakota Medical Assistance Program Department address and page number;
- Type of Remittance Advice (e.g. nursing home, physician, pharmacy, crossover, etc.) and date;
- Provider name, address, and Medical Assistance Program provider ID number.

REMITTANCE ADVICE FORMAT

Only the last nine (9) digits of the recipient's 14 digit identification number are displayed.

MESSAGES:
The Remittance Advice is used to communicate special information to providers. Policy changes, service limitations, and billing problems are examples of messages that may be published in this section. **READ CAREFULLY ALL MATERIAL PRINTED IN THESE MESSAGES AND ENSURE THAT THE APPROPRIATE STAFF RECEIVES A COPY OF THE MESSAGE.**

THE FOLLOWING CLAIMS ARE APPROVED ORIGINALS**:**
Approved (paid): A claim is approved (paid) if it is completely and correctly prepared for a Medical Assistance Program covered service(s) provided to an eligible recipient by a Medical Assistance Program enrolled provider of health care services.
Claims that have been determined payable are listed in this section with the amount paid by Medical Assistance Program.

THE FOLLOWING CLAIMS ARE DEBIT REPLACEMENTS:
A replacement can be processed only for a claim that has previously been paid. When adjusting a claim, resubmit the complete original claim with the corrections included or deleted as appropriate.

NOTE: Once you have adjusted a claim you cannot adjust or void that same claim again.

THE FOLLOWING CLAIMS ARE CREDIT REPLACEMENTS**:**
This is the other half of the replacement process. The reference number represents the **original paid claim**. Information in this section reflects the Medical Assistance Program processing of the original paid claim. This information is being replaced by the correct information, listed in the section above (THE FOLLOWING CLAIMS ARE DEBIT REPLACEMENTS:).

THE FOLLOWING CLAIMS ARE VOID**:**
This section subtracts claims that should not have been paid. The first reference number represents the **voided claim.** The second reference number represents the **original paid claim**(the claim that is being voided). Transactions on this line show a negative amount for the provider.

NOTE: Once you have voided a claim, you cannot void or adjust the same claim again.

CLAIM TOTAL – See Remittance Total below.

THE FOLLOWING CLAIMS ARE DENIED**:**
A claim is denied if one or more of the following conditions exist:

- The service is not covered by the Medical Assistance Program;
- The claim is not completed properly;
- The claim is a duplicate of a prior claim;
- The data is invalid or logically inconsistent;
- Program limitations or restrictions are exceeded;
- The services is not medically necessary or reasonable; and
- The patient and/or provider is not eligible during the service period.

Providers should review denied claims and, where appropriate, completely resubmit the claim with corrections. Providers should not resubmit claims that have been denied due to practices that contradict either good medical practice or the Medical Assistance Program policy.

Claims that cannot be paid by Medical Assistance Program are listed in this section. Even though there may be several reasons why a claim cannot be paid, only one denial reason will be listed.

*ADD-PAY/RECOVERY REASONS***: MISCELLANEOUS**

When an adjustment or void has not produced a correct payment, a lump sum **payment or deduction** is processed. There is no identifying information on the remittance advice about what recipient or services this payment is made for. A letter is sent to the provider explaining the add-pay/recovery information. If the amount is to be subtracted from the provider there will be a minus sign behind the amount; Otherwise the amount is a payment to the provider.

REMITTANCE TOTAL

The total amount is determined by adding and subtracting all of the amounts listed under the column **PAID BY PROGRAM.**

YTD NEGATIVE BALANCE
A Year-to Date (YTD) negative balance is posted in one of two situations. When ONLY void claims are processed in a payment cycle for the provider and no original paid claims are included on the remittance advice, a negative balance is displayed. When the **total amount** of the negative transactions, such as credit replacement and void claims, is larger than the total amount of positive transactions (original paid and debit replacements), a negative balance will be shown.

MMIS REMIT NO ACH AMOUNT OF CHECK
The system produces a sequential remittance advice number that is used internally for finance purposes and relates to the check/ACH issue to the provider. The net check amount is the **REMITTANCE TOTAL** minus the **YTD NEGATIVE BALANCE.**

PENDED CLAIMS – THE FOLLOWING CLAIMS ARE PENDED FOR REVIEW – PROVIDER DOES NOT NEED TO TAKE ACTION UNLESS FURTHER CONTACT IS MADE:

A claim that cannot be automatically paid or denied through the normal processing system is pended until the necessary corrective action has been taken. Claims may be pended for erroneous information, incomplete information, information mismatch between the claim and the state master file, or a policy requirement for special review of the claim. The reason for pending the claim is printed on the Remittance Advice. The provider should wait for claim payment or denial before resubmitting the claim.

After a pended claim has been approved for further processing, it is reprocessed and appears on the subsequent remittance advice as an approved original either as a paid or a denied claim.

DO NOT SUBMIT A NEW CLAIM FOR A CLAIM IN PENDED STATUS, UNLESS YOU ARE ADVISED BY THE DEPARTMENT TO DO SO.

IF ERRORS ARE IDENTIFIED ON THE REMITTANCE ADVICE, PLEASE NOTIFY THE MEDICAL ASSISTANCE PROGRAM AT 1-800-452-7691 AS SOON AS POSSIBLE.

CHAPTER V

COST SHARING

COST SHARING

Cost sharing for enteral nutritional services provided to an individual age 21 or over is $2 a day. Cost sharing for parenteral nutritional therapy provided to an individual age 21 or over is $5 a day. An individual under age 21 is exempt from cost sharing.

CHAPTER VI

ADMINISTRATIVE RULE

For nutritional therapy and nutritional supplements Administrative Rule of South Dakota 67:16:42

Click Here

APPENDIX A

CERTIFICATE OF MEDICAL NECESSITY

NUTRITIONAL THERAPY

CERTIFICATE OF MEDICAL NECESSITY

NUTRITIONAL THERAPY

All of the following information is required in order for nutrition to be covered. This form must be contained in the recipient's clinical records.

RECIPIENT NAME:_____

MEDICAL ASSISTANCE ID NUMBER:_____

DIAGNOSIS – INCLUDING AN EXPLANATION OF THE PARTICULAR PROBLEM RESULTING FROM THE DIAGNOSIS WHICH RELATES TO THIS NUTRITION REQUEST:

_____

_____

_____

PROGNOSIS: _____

_____

HOW LONG IS THIS PROBLEM EXPECTED TO LAST? MONTHS___ INDEFINITELY___ PERMANENTLY___

EXPLANATION OF THE MEDICAL NECESSITY/JUSTIFICATION FOR AUTHORIZATION:

_____

INDIVIDUAL'S SOLE SOURCE OF NUTRITION: YES_____ NO_____
INDIVIDUAL RESIDES AT HOME: YES_____ NO_____

NUTRITION BEING PRESCRIBED:

_____

_____

_____

PHYSICIAN'S SIGNATURE: _____DATE: _____

PROVIDER NAME AND ADDRESS: _____

_____

PROVIDER IDENTIFICATION NUMBER: _____

CONTACT PERSON: _____

APPENDIX B

Parenteral Nutrition HCPCS Codes

B4164	Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) -- home mix
B4168	Parenteral nutrition solution: amino acid, 3.5%, (500 ml = 1 unit) -- home mix
B4172	Parenteral nutrition solution: amino acid, 5.5% through 7 %, (500 ml = 1 unit) -- home mix
B4176	Parenteral nutrition solution: amino acid, 7% through 8.5%. (500 ml = l unit) -- home mix
B4178	Parenteral nutrition solution: amino acid, greater than 8.5%. (500 ml = 1 unit) -- home mix
B4180	Parenteral nutrition solution: carbohydrates (dextrose), > 50 % (500 ml = l unit) -- home mix
B4184	Parenteral nutrition solution: lipids, 10% with administration set (500 ml = 1 unit)
B4186	Parenteral nutrition solution: lipids, 20% with administration set (500 ml = 1 unit)
B4189	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein -- premix
B4193	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein -- premix
B4197	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 74 to 100 grams of protein -- premix
B4199	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, over 100 grams of protein -- premix
B4216	Parenteral nutrition: additives (vitamins, trace elements, heparin, electrolytes) home mix per day

B4220	Parenteral nutrition supply kit: premix, per day
B4222	Parenteral nutrition supply kit: home mix per day
B4224	Parenteral nutrition administration kit, per day
B5000	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal -- Aminosyn RF , Nephramine, Renamin -- premix
B5100	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic -- Freamine HBC, Hepatamine -- premix
B5200	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress -- branch chain amino acids -- premix
B9004	Parenteral nutrition infusion pump, portable
B9006	Parenteral nutrition infusion pump, stationary
B9999	NOC for parenteral supplies